St Elizabeth

URGENT CARE & FAMILY PRACTICE

PATIENTS INFORMATION SHEET

(Please fill out entire sheet)

Angel Rivera, M.D. ☐ **Dorothy Merritt, M.D.** ☐ **Nadia Nekooi, PA-C** ☐ **Gary Spangler, M.D.** ☐

Clay Golightly, PA-C ☐ **Greg Mrozinski, N.P.** ☐

Chose clinic because/Referred to clinic by (please check one box): **Dr.** ☐ **Insurance Plan** ☐ **Hospital** ☐ **Family** ☐

Friend ☐ **Internet** ☐ **Close to home/work** ☐ **Billboard** ☐ **Print** ☐ **Other** ☐ _____

Name: _____ **DOB:** _____ **AGE:** _____
(LAST, FIRST)

Address: _____ **Social Security:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

Home Phone: ( ) _____ **CELL:** ( ) _____ **WK Phone:** ( ) _____

Martial Status: S M W D **Student:** Y or N **MALE** or **FEMALE**

Ethnicity: (Circle one) **White Hispanic Black Asian American Indian Other:** _____

Employer: _____ **Occupation:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Referred by: _____

- **If Parent or Spouse is Responsible for Patient – Please Complete Guarantor Information**

Guarantor Name: _____ **DOB:** _____ **Relation:** _____

Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Social Security: _____ **Work Phone:** _____

Primary Insurance: _____ Subscriber# _____ Group: _____

Secondary Insurance: _____ Subscriber#: _____ Group: _____

Staff Initial: _____ **Date:** _____
(St. Elizabeth Family Care Staff)